STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365410	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayfair Village Nursing Care C	3000 Bethel Rd Columbus, OH 43230

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview and facility policy review the facility failed to maintain a medication error rate of five percent or less. This affected one resident (#45) of six residents observed during medication administration. The facility census was 86.Findings include: 1. On 11/26/25 at 9:00 A.M. through 11:16 A.M. and 12/01/25 from 8:08 A.M. through 8:21 A.M. medication pass was observed for six residents (#2, #30, #45, #73, #75, and #76) provided by five facility staff nurses. A total of 26 observations were made with two errors resulting in an error rate of 7.69%.Record review of Resident #45's medical record revealed an admission date of 04/02/2019. Diagnoses include unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, chronic kidney disease stage III, unspecified atrial fibrillation, other specified peripheral vascular diseases, essential (primary) hypertension, anemia, presence of cardiac pacemaker, dysphagia oropharyngeal phase, muscle weakness, edema, vitamin deficiency, nail dystrophy, presence of intraocular lens, and long term (current) use of anticoagulants.Review of Resident #45's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) could not be completed due to resident is rarely/never understood and confirms Resident #45's cognitive skills for daily decision making is severely impaired.Review of Resident #45's Medication Administration Record (MAR) dated 12/01/25 revealed Resident #45 had an order for Metoprolol Succinate Oral Capsule ER 24 Hour Sprinkle 100 milligrams (mg) instructions include give one capsule by mouth one time a day for hypertension and hold if systolic blood pressure is less than 110 with an order date of 12/23/24. Resident #45 had an order for Potassium (electrolyte) tablet instructions include give 20 milliequivalent (mEq) by mouth one time a day for hypokalemia with an order date of 12/22/19.Observation on 12/01/25 at 8:25 A.M. of Licensed Practical Nurse (LPN) #74 during medication administration revealed Resident #45 receive Metoprolol Succinate ER 100 mg, one tablet, Potassium CL ER 20 mEq, one tablet, and Eliquis (anticoagulant) 2.5 mg, one tablet. The three medication tablets were then crushed and placed in pudding and administered to Resident #45. Observation of medication cards for Metoprolol Succinate ER 100mg and Potassium CL ER 20 mEq were labeled do not crush on left upper corner.Interview 12/01/25 at 9:10 A.M. with LPN #74 confirmed the medications provided were crushed and administered to Resident #45.LPN #47 was observed to call Pharmacist #20 on speaker phone on 12/01/25 at 9:14 A.M. and Pharmacist #20 confirmed Metoprolol Succinate ER 100 mg tablet and Potassium CL ER 20 mEq tablet should not be crushed. Review of the facility's Administration of Medications policy dated 09/09/25 confirmed staff who are responsible for medication will adhere to the 10 rights of medications administration. Right drug, compare the order with the medication administration record (eMAR) for accuracy and compare the label on the drug to the information on the eMAR, three times. Verify the right resident. Right dose and if there is any doubt about the dose on the MAR or if there is a question on the drug, stop and verify all information before administering. Review of the facility's policy titled, Medication - Related Errors dated 05/01/10 confirms if a medication reaches a resident in error, the facility should, notify the pharmacy of ay possible dispensing occurrence; and notify physician/prescriber and obtain further instructions and/or orders. Facility staff should monitor the resident in accordance with physician/prescriber's instructions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and facility policy review the facility failed to administer medications as ordered for Resident #45. This affected one of five residents observed during medication administration. The facility census was 86.Findings include:Record review of Resident #45's medical record revealed an admission date of 04/02/2019. Diagnoses include unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, chronic kidney disease stage III, unspecified atrial fibrillation, other specified peripheral vascular diseases, essential (primary) hypertension, anemia, presence of cardiac pacemaker, dysphagia oropharyngeal phase, muscle weakness, edema, vitamin deficiency, nail dystrophy, presence of intraocular lens, and long term (current) use of anticoagulants.Review of Resident #45's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) could not be completed due to resident is rarely/never understood and confirms Resident #45's cognitive skills for daily decision making is severely impaired.Review of Resident #45's Medication Administration Record (MAR) dated 12/01/25 revealed Resident #45 had an order for Metoprolol Succinate Oral Capsule ER (antihypertensive) 24 Hour Sprinkle 100 MG instructions include give one capsule by mouth one time a day for hypertension and hold if systolic blood pressure is less than 110 with an order date of 12/23/24. Resident #45's Potassium (supplement) tablet instructions include give 20 mEq by mouth one time a day for hypokalemia with an order date of 12/22/19.Observation on 12/01/25 at 8:25 A.M. of License Practical Nurse (LPN) #74 during medication administration revealed Resident #45 receive Metoprolol Succinate ER 100mg one tablet, Potassium CL ER 20 mEq one tablet, and Eliquis 2.5 mg one tab. The three medication tablets were then crushed and placed in pudding and administered to Resident #45. Observation of medication cards for Metoprolol Succinate ER 100mg one tablet and Potassium CL ER 20 mEq one tablet were labeled do not crush on left upper corner.Interview 12/01/25 at 9:10 A.M. with LPN #74 confirmed the three medications were crushed and administered to Resident #45.Observation on 12/01/25 at 9:14 A.M. of LPN # 47's interview with Pharmacist #20 confirmed Metoprolol Succinate ER 100 mg tablet and Potassium CL ER 20 mEq tablet should not be crushed.LPN #47 was observed to call Pharmacist #20 on speaker phone on 12/01/25 at 9:14 A.M. and Pharmacist #20 confirmed Metoprolol Succinate ER 100 mg tablet and Potassium CL ER 20 mEq tablet should not be crushed. Review of the facility's Administration of Medications policy dated 09/09/25 confirmed staff who are responsible for medication will adhere to the 10 rights of medications administration. Right drug, compare the order with the medication administration record (eMAR) for accuracy and compare the label on the drug to the information on the eMAR, three times. Verify the right resident. Right dose and if there is any doubt about the dose on the MAR or if there is a question on the drug, stop and verify all information before administering. Review of the facility's policy titled, Medication - Related Errors dated 05/01/10 confirms if a medication reaches a resident in error, the facility should, notify the pharmacy of any possible dispensing occurrence; and notify physician/prescriber and obtain further instructions and/or orders. Facility staff should monitor the resident in accordance with physician/prescriber's instructions.This violation represents non-compliance investigated under Complaint Number 2647703.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and facility policy review the facility failed to properly label and store medications. This had the potential to affect all residents who receive medications from the facility. The census was 86. Findings include: 1. Observation on [DATE] at 9:39 A.M. with Licensed Practical Nurse (LPN) #52 during medication administration revealed a facility stock bottle of Thiamine B1 (vitamin) 100 milligram (mg) tablet which was opened and undated, a facility stock bottle of Famotidine (decreases acid in the stomach) 20 mg bottle which was opened and undated, and container of MiraLAX (laxative)17 mg which was opened and undated. Other facility stock medication bottles were observed in medication cart had open dates written on top of lid of medication bottle.Interview on [DATE] at 9:45 A.M. with LPN #52 confirmed the bottles of Thiamine, Famotidine, and MiraLAX were open but were not labeled with the open date. LPN #52 was observed labeling the bottles. 2. Observation on [DATE] at 11:25 A.M. of the medication storage room revealed unopened but expired items including a bottle of Fiber Powder Psyllium husk with the expiration of [DATE], a bottle of Vitamin A 3,000 mcg, B2 Riboflavin with an expiration date of [DATE], nasal spray moisturizing spray with an expiration date of [DATE], and nasal decongestant PE Phenylephrine HCL 10 mg expiration date of [DATE].Interview on [DATE] at 11:45 A.M. with the Assistant Director of Nursing (ADON) confirmed the medications were expired.Review of the facility's policy titled, Storage and Expiration Dating of Medications and Biologicals last revised on [DATE] confirms the facility should ensure medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines,: or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier.